

## **SECTION V.10. Enrollment & Billing Procedures**

### **A. Provider Enrollment**

All Choices for Care (CFC) providers must enroll as a CFC provider in the Medicaid claims processing system via Electronic Data Systems (EDS). The following procedures shall be used to enroll CFC service providers:

1. The **interested agency or organization** must contact the Department of Disabilities, Aging and Independent Living (DAIL) CFC administration to request DAIL authorization to provide specific CFC services. The interested provider must provide the following information to DAIL in writing:
  - The name of the provider agency or organization
  - The address, phone number, and fax number of the agency or organization
  - Contact person in the agency or organization (for purposes of discussing provider eligibility and provider enrollment)
  - Requested effective date of Medicaid Waiver provider status
  - The service(s) which the agency or organization would like to provide
2. **DAIL** may contact the agency or organization to request additional information, and may visit the agency or organization prior to approving or denying the request.
3. If **DAIL** denies the request, **DAIL** will communicate this in writing to the organization.
4. If **DAIL** authorizes the request, **DAIL** will send an authorization memo to EDS, the Department for Children and Families (DCF), and the agency or organization, including the following:
  - The name of the provider agency or organization
  - The address, phone number, and fax number of the agency or organization
  - Contact person in the agency or organization (for purposes of provider enrollment)
  - The requested effective date of Medicaid CFC provider status
  - The service(s) which the agency or organization is authorized to provide
5. The CFC provider will obtain a copy of all the applicable sections of the CFC Manual, brochure and Referral forms (when applicable).
6. The CFC provider must contact EDS provider enrollment (802-879-4450) to request an enrollment form. The form must be fully completed and submitted to EDS.
7. **EDS Provider Enrollment and Recertification staff** (802-879-4450) will assure that the provider has completed a Medicaid provider enrollment agreement, assign a provider number and confirm the provider's enrollment in writing to the provider.
8. Any problems or obstacles in provider enrollment will be addressed by negotiation between **EDS, DAIL, and the potential service provider**.

## **B. Claims**

1. **CFC service providers** shall only submit claims for Medicaid reimbursement for services that have been provided to eligible individuals in compliance with applicable service definitions, provider qualifications, and standards.
2. **CFC service providers** shall submit all claims for CFC services through Vermont's Medicaid Management Information System (MMIS), managed by Vermont's Medicaid fiscal intermediary, Electronic Data Systems (EDS), in accordance with EDS procedures. Questions about CFC service claims, payments, and claims procedures should be addressed to EDS (802-879-4450).
3. **CFC service providers** shall have mechanisms or procedures to assure that claims which are submitted are accurate, and in compliance with all applicable CFC procedures and regulations.
4. **CFC service providers** are responsible for preparing and submitting claims for services that they provide. Exceptions:
  - a. 076: Home-Based Waiver Assistive Devices and Modifications: Services may be provided by a variety of organizations or individuals. Services shall be billed through the individual's case management agency if the provider is not enrolled as a LTCM provider. The following billing dates are to be used:
    - Assistive Devices: The billing date (date of service) will always be the date the item was received by the individual.
    - Home Modifications: The billing date (date of service) will always be the date the home modification work was completed.
    - Loans/Payment plans: The billing date (date of service) will always be the date the payment is made to the service provider as part of a payment plan established by the case manager in advance.
  - b. 077, 081, 075, 080: Consumer-Directed and Surrogate-Directed Services: Services are provided by workers employed by the consumer or surrogate employer. Services shall be billed through an intermediary service organization (a payroll agent for consumer employers and surrogate employers).
5. **CFC service providers** shall submit claims using the correct revenue code, as described in the following table.
6. The Service Plan must be approved by **DAIL** and received by the **service provider** before any claims for CFC services may be submitted to the Medicaid claims processing system (Electronic Data Systems [EDS]).
7. **CFC service providers** must obtain and retain copies of the approved Service Plan for every waiver participant to whom waiver services are provided. The approved Service Plan specifies the type, frequency and volume of CFC services, as well as the start date and end date of approval. Only claims for services that comply with the details and limitations of the approved Service Plan may be submitted to the Medicaid claims processing system.

8. **DAIL** will consider retroactive requests for Service Plan increases (HB & ERC) only under certain circumstances when a precipitating event necessitates an immediate increase of services exceeding the currently approved volume of services.
  - a. The immediate increase must be necessary to prevent harm to the individual, a hospitalization or nursing home placement. For example: The home-based primary caregiver is hospitalized or the individual has a medical event that requires immediate increase in services.
  - b. Retroactive Service Plan changes will not be approved to cover administrative errors or non-emergent requests for increases.
  - c. All requests for retroactive coverage must accompany a Service Plan change, a written request for a specific start date and a description of the precipitating event.
  - d. The effective date of the change or changes shall be no greater than six months preceding the date that the request is received by DAIL.
9. If a **CFC service provider** submits any claims for any waiver services that exceed the dates, types and/or amounts of services that are authorized by an approved Service Plan, the service provider must arrange recoupment (or re-payment) to EDS of all payments for services that exceed the dates, types and/or amounts authorized.
10. If a **CFC service provider** submits any claims for any waiver services which exceed the types and amounts of services actually provided to an eligible individual (but are within the dates, types and amounts of services which are authorized by an approved Plan of Care), the service provider must arrange recoupment (or re-payment) to EDS of all payments for services which exceed the amount actually provided.
11. **Case Management** services may be provided and billed for up to 180 days after admission and/or preceding discharge from a nursing home or hospital, when such services are clearly documented as facilitating the individual's return to the community. Claims for such case management services must be submitted after the actual date of discharge from the hospital or nursing home, as a single claim.

### **C. Revenue Codes and Rates**

As of July 2008, all Choices for Care billing revenue codes and rates are maintained and located in the “**DAIL/DDAS Services: Medicaid Claims Codes and Reimbursement Rates**” table at <http://www.ddas.vermont.gov/ddas-publications/publications-idu/publications-idu-documents/dail-ddas-service-codes-and-rates-jul-2008>. The table is found on the DAIL/DDAS website under Choices for Care Publications and Reports, Other Helpful Publications, DAIL-DDAS Service Codes and Rates. <http://www.ddas.vermont.gov/ddas-publications/publications-idu/publications-idu-default-page#rates>